(K) Facility Fiscal Year. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

(L) Generally Accepted Accounting Principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing such principles.

(M) Long-Term Care Facility. A licensed SNF, ICF, ICF/MR, SNF/ICF, RCFI, RCFII or other provider of long-term care services.

(N) New Facility. A newly built facility, for which an approved Certificate of Need or applicable waiver was obtained and which was newly completed and operational on or after July 1, 1989, and which was originally certified for participation as a skilled nursing facility.

(O) Occupancy. A facility's total actual patient days divided by the total licensed bed days for the same period.

(P) Patient Day. The period of service rendered to a patient between the census taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the twelve (12) temporary leave of absence days per any period of six (6) consecutive months for which the Medicaid program

will reimburse the provider. The day of discharge is not a patient day for reimbursement purposes unless it is also the day of admission.

(Q) Pediatric Nursing Care Facility (Facility). Either a new facility with all of the following attributes, or a long-term care facility with a valid Medicaid participation agreement in effect on June 30, 1989 with all the following attributes on or before June 30, 1990:

1. The facility must be licensed under Chapter 198 RSMo 1986 and must have any other licenses and/or permits which may be required by applicable state and local laws;

2. The facility must have one hundred percent (100%) of all licensed beds certified by the Division of Aging as meeting the conditions for participation in the Medicaid Program as a skilled nursing facility;

3. The facility cannot be either attached to or a distinct part of any other long-term care facility or hospital. Distinct part means any portion of any long-term care facility or hospital, less than the total beds of the long-term care facility or hospital;

4. The facility must serve only persons under the age of twenty-one (21);

5. The facility must be located in the State of Missouri; and

6. The facility must have a valid participation agreement in effect with the Missouri Division of Medical Services.

(R) Provider. Either a new facility with all of the following attributes, or a long-term care facility with a valid Medicaid participation agreement in effect on June 30, 1989 with all of the following attributes on or before June 30, 1990:

1. The facility must be licensed under Chapter 198 RSMo. 1986 and must have any other licenses and/or permits which may be required by applicable State and local laws;

2. The facility must have on-hundred percent (100%) of all licensed beds certified by the Division of Aging as meeting the conditions for participation in the Medicaid Program as a skilled nursing facility;

3. The facility cannot be either attached to or a distinct part of any other long-term care facility or hospital. Distinct part means any portion of any long-term care facility or hospital, less than the total beds of the long-term care facility or hospital;

4. The facility must serve only persons under the age of twenty-one (21);

5. The facility must be located in the State of Missouri; and

6. The facility must have a valid participation agreement in effect with the Missouri Division of Medical Services.

(S) Related Parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those which are usual and customary in such dealings.

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or through a subsidiary, operates a facility.

3. As used in the section the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock or in the profits of an entity;

C. Ownership or controlling interest is when an entity --

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust note or other obligation secured by an entity if that interest equals at lease five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or direct of an entity; or

(VI) Is a partner in an entity that is organized as a partnership.

D. Relative means person related by blood, adoption or marriage to the fourth degree of consanguinity.

(T) Restricted Funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments which must only be used for a specific purpose designated by the donor.

(U) Second Prior Year Cost Report. The cost report for the facility fiscal year which ends in the second calendar year prior to the calendar year in which the state's fiscal year ends. For example, for State Fiscal Year 1990, the second prior year cost report would be the cost report for a facility fiscal year which ends any time in calendar year 1988.

(V) Skilled Nursing Facility. A long-term care facility licensed and certified by the Division of Aging as meeting the conditions for participation in the Medicaid Program as a skilled nursing facility.

(W) Unrestricted Funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the per-diem rate must be provided to the resident

as necessary, and the facility may not charge the resident, any entity, or any other payor any additional amounts for these items, except that supplies and services which would otherwise be covered in a per-diem rate but which are also billable to the Title XVIII Medicare Program must be billed to that program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and supplies which must be provided by Skilled Nursing Facilities as set forth in Title 42 Code of Federal Regulations;

(B) Semi-private room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition examples of which may be contagious infection, loud irrational speech, etc.;

(D) Temporary leave of absence days, not to exceed twelve (12) days per any period of six (6) consecutive months;

(E) Provision of nursing services;

(F) Provision of personal hygiene and routine care services;

(G) All laundry service, including personal laundry;

(H) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(I) All consultative services required by federal or state law or regulation;

(J) All therapy services required by federal or state law or regulation;

(K) All routine care items, including disposables and including but not limited to those items specified in Appendix A to this regulation;

(L) All nursing care services and supplies, including disposables, and including but not limited to those items specified in Appendix A to this regulation;

(M) Any and all non-legend antacids, non-legend laxatives, non-legend stool softeners and non-legend vitamins. Providers may not elect which non-legend drugs in and of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's per-diem rate:

(6) Non-Covered Supplies, Items and Services. All supplies, items and services which are not either covered in a facility's per-diem rate, billable to another program in the Missouri Medical Assistance (Medicaid) Program, or billable to Medicare or other third party payors. Non-covered supplies, items and services include, but are not limited to the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition examples of which may be contagious infection, loud irrational speech, etc.;

(B) Bed reservations for recipients who are away from the facility for any reason other than a temporary leave of absence day. Temporary leave of absence days in excess of twelve (12) per any period of six (6) consecutive months are non-covered.

(C) Supplies, items and services for which payment is made under Missouri Medical Assistance (Medicaid) Program directly to a provider or providers other than providers of the pediatric nursing care services, including but not limited to those set forth in Appendix B to this regulation; and

(D) Supplies, items and services provided non-routinely to residents for personal comfort or convenience, including but not limited to those set forth in Appendix B to this regulation.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area, provided the services are actually performed, are necessary, and reasonable.

2. Compensation shall mean the total benefit, within the limitations set forth in this plan, received by the owner for the services she/he renders to the facility including direct payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and

services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method enumerated previously described in this rule. Compensation must be paid (whether in cash, negotiable instrument, or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the Medicare Provider Reimbursement Manual PRM, Part 1, Section 906.4.

3. Reasonableness of compensation shall be limited as prescribed in subsection (8)(T).

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility, had the owner not rendered these services, then employment of another entity to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this Plan.

(C) Real Estate and Personal Property Taxes. Taxes levied on or incurred by a facility.

(D) Value of Services of Employees. Except as provided for in this rule, the value of services performed by employees or contractors in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the contractor.